APPLICATION FOR REGISTRATION AS A CONTINUING CARE PROVIDER
Prescribed by the Indiana Secretary of State Securities Commissioner

INSTRUCTIONS:

Pursuant to IC 23-2-4-3, each retirement home providing continuing care agreements must register with the Indiana Secretary of State Securities Division. Such registration shall include an initial disclosure statement as described in IC 23-2-4-4, along with other information required by the Commissioner.

A) If the home is making an initial registration, the following must be submitted with the application:

1) Filing fee of $250;

2) An initial disclosure statement containing all information required by IC 23-2-4-4;

3) Certified financial statements, including a balance sheet as of the end of the provider's last fiscal year and an income statement for the last three (3) fiscal years or such shorter period of time as the home has been in operation;

4) Copies of forms of agreement for continuing care used by the provider.

B) If the home is making a renewal registration, the following must be submitted with the application:

1) Filing fee of $100;

2) An annual disclosure statement in accordance with IC 23-2-4-5 including an income statement and balance sheet for the last fiscal year;

3) Copies of forms of agreement for continuing care used by the provider.

C) If the operation of the home has not begun, the following must be submitted with the application:

1) Filing fee of $250;

2) An initial disclosure statement containing all information required by IC 23-2-4-4;

3) A statement of the anticipated source and application of funds to be used in the purchase or construction of the home, and an estimate of the funds, if any, which are anticipated to be necessary to pay for start-up losses;

4) Copies of forms of agreement for continuing care to be used by the provider.

Revised: October 2003

APPLICATION FOR REGISTRATION AS A CONTINUING CARE PROVIDER AS PRESCRIBED BY THE INDIANA SECURITIES DIVISION

Check appropriate line for this filing:

_____ **Initial** Disclosure Statement
$250 Registration Fee

_____ **Annual** Disclosure Statement
$100 Renewal Fee

ANNUAL RENEWALS ARE DUE 120 DAYS FOLLOWING FISCAL YEAR END

Fiscal Year End: _____/_____/_____
mm dd yy

1. **Name of Facility** _____

   Street Address _____

   City, State, ZIP _____

   Telephone _____
   (Area Code and Number)

   Fax _____
   (Area Code and Number)

   Contact Person and Title _____

2. **Provider's Name** _____

   Street Address _____

   City, State, ZIP _____

   Telephone _____
   (Area Code and Number)

   Fax _____
   (Area Code and Number)

   Contact Person and Title _____

3. **In an effort to determine the risk exposure to the Indiana Retirement Home Guaranty Fund into which your residents' $100 fee for continuing care contracts are invested, please provide the potential liability or refunds that may, at any time, be paid back to residents or their estates. Please be specific as to dollar amount and date.**

_____ _____
$$ - Potential Refunds **As of: mm/dd/yy**

4. Attach a copy of all residency agreements and/or contracts offered at this facility - if not already a part of the Annual Disclosure Statement.

5. List the name and address of the escrow agent used by the provider for the deposit of entrance fees received from residents prior to occupancy. (Note: If any portion of an entrance fee is received from a continuing care resident, the law requires that such money be held in escrow until the resident takes occupancy.) _____
_____
_____

6. Attach a copy of the agreement entered into between escrow agent and provider.

7. List the name and address of any other home currently or previously operated by the provider or manager of this home. _____
_____
_____
_____

8. If the operation of the home has not begun, attach a statement of the anticipated source and application of funds to be used in the purchase or construction of the home, and the estimate of the funds, if any, which are anticipated to be necessary to pay for start-up losses.

9. Does this facility offer rental contracts or agreements? _____

** If yes, are meals, health-related services, or a combination of such included in the fee? _____
Please provide details of those services. _____
_____
_____

10. Does this facility offer continuing care contracts? _____

** If no, is the facility honoring pre-existing continuing care contracts? _____

11. Does this facility have a health center, nursing home, or similar on campus? _____

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COMPLETE THE CHART ON THE FOLLOWING PAGE

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COMPLETE ALL APPLICABLE LINES BELOW

Occupancy information is current as of: _____/_____/_____
mm dd yy

		CONTINUING CARE CONTRACTS		DAILY RATE or RENTAL CONTRACTS	
TYPE OF UNIT	TOTAL UNITS, ROOMS, OR BEDS AVAILABLE	TOTAL OCCUPIED UNITS	TOTAL # OF RESIDENTS OR PATIENTS	TOTAL OCCUPIED UNITS	TOTAL # OF RESIDENTS OR PATIENTS
Studio					
1 - Bedroom					
2 - Bedroom					
3 - Bedroom					
Cottage					
Health Center					
Other					
	(A)	(B)	(C)	(D)	(E)

(A) = Total units making up the entire community
(B) = Total units occupied under continuing care contracts
(C) = Total number of residents living in (B)
(D) = Total units occupied under daily rate or non-continuing care rental contracts
(E) = Total number of residents living in (D)

Note: (B) + (D) should be less than or equal to (A).

THIS APPLICATION / RENEWAL IS COMPLETE WHEN WE HAVE RECEIVED:

_____ Current disclosure statement

_____ This completed application form

_____ Current audited financial statements - as of most recent fiscal year end

_____ Filing fee